DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/17/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			D. WILLO			R-C	
		155532	B. WING			11/	10/2014
NAME OF P	ROVIDER OR SUPPLIER			,	STREET ADDRESS, CITY, STATE, ZIP CODE		
DI COMINI	CTON NUDCING AND D	THA DILLITATION OF NITED			120 E MILLER DR		
BLOOMINGTON NURSING AND REHABILITATION CENTER				BLOOMINGTON, IN 47401			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI				COMPLETION DATE
TAG			TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	AIE	
{F 000}	INITIAL COMMENTS		{F 0	000	}		
	This visit was for the	Post Survey Revisit (PSR)					
		Complaint IN00154694					
	completed on Septen						
	This visit was in conjunction with the Investigation of Complaint IN00158880.						
	Complaint IN0015469	94 - Corrected.					
	0						
	Survey date: November 10, 2014						
	November 10, 2014						
	Facility number: 00	00460					
	Provider number: 15	5532					
	AIM number: 100290620						
	Survey team: Diana Zgonc, RN-TC						
	Canava had hyna.						
	Census bed type: SNF/NF: 34						
	Total: 34						
	Total. 54						
	Census payor type:						
	Medicare: 2						
	Medicaid: 29						
	Other: 3						
	Total: 34						
	Sample: 3						
	σαπιριε. σ						
		and Rehabilitation Center					
		mpliance with 42 CFR Part					
		10 IAC 16.2-3.1 in regard to					
	the PSR to the Invest	igation of Complaint					
	IN00154694.						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER BLOOMINGTON NURSING AND REHABILITATION CENTER BLOOMINGTON NURSING AND REHABILITATION CENTER BLOOMINGTON, IN 47401 (PATION REPORT AND REHABILITATION CENTER) (PATION REPORT AND REHABILITATION CENTER BLOOMINGTON, IN 47401 (PATION REPORT AND REPORT AND CORPECTION, IN A 17401 (PATION RESOLUCION RE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCT		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER BLOOMINGTON NURSING AND REHABILITATION CENTER 120 E MILLER DR 120 E			455522	P WING			1	
BLOOMINGTON NURSING AND REHABILITATION CENTER 120 E MILLER DR BLOOMINGTON, IN 47401	NAME OF P	ROVIDER OR SUPPLIER	155532	B. WING _	<u> </u>			10/2014
BLOOMINGTON NURSING AND REHABILITATION CENTER (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (F 000) Continued From page 1 Quality review completed on November 14, 2014;	NAME OF T	TOVIDER OR GOLT EIER						
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE COMPLETION DATE COMPLETION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	BLOOMIN	GTON NURSING AND R	EHABILITATION CENTER					
Quality review completed on November 14, 2014;	PREFIX	(EACH DEFICIENC	PREFIX	PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE AF		LD BE COMPLETION		
	{F 000}	Quality review compl	eted on November 14, 2014;	{F 0	00}	DEFICIENCY)		